



# Report of an inspection of a Designated Centre for Older People.

## Issued by the Chief Inspector

Name of designated centre:	Birr Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Sandymount, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	13 October 2021
Centre ID:	OSV-0000522
Fieldwork ID:	MON-0034257

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Birr community Nursing Unit is a single-storey facility located in a quiet residential area, within walking distance of Birr town centre. The centre can accommodate 76 residents over the age of 18 years, both male and female for long term and respite care. Two beds are also dedicated to rehabilitation care. Accommodation is set out in three suites, Laurel, Sandymount and Camcor with communal dining and sitting rooms in each suite. Bedroom accommodation for residents is provided in two bedrooms with four beds, 13 bedrooms with three beds, eight twin bedrooms and 13 single bedrooms. Twenty six bedrooms have en suite toilet, wash basin and shower facilities and 10 bedrooms have toilet and wash basin facilities only. A palliative care suite is available in the centre. Services provided include 24 hour nursing care of residents with the following needs; general care, mental health, palliative care and dementia. A medical officer and health and social care professionals are provided as part of the service to residents.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	60
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### **1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### **2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Wednesday 13 October 2021	09:30hrs to 17:00hrs	Sean Ryan	Lead
Thursday 14 October 2021	08:00hrs to 13:00hrs	Sean Ryan	Lead

## What residents told us and what inspectors observed

Overall, the inspector found that residents living in Birr Community Nursing Unit received good quality health care from a team of staff that were dedicated to enhancing the quality of life of the residents.

The inspector observed resident and staff engagement throughout the inspection. It was evident that staff knew residents well and residents were comfortable and relaxed in the presence of staff. All interactions were conducted in a caring and respectful manner. Residents spoken with were complimentary of the staff and commented that they were responsive to their requests for assistance. The only source of dissatisfaction expressed by residents was the size and availability of communal space within each of the three units and the provision of consistent activities.

This unannounced inspection was carried out during the COVID-19 pandemic over two days. The inspector arrived at the centre and was met by a member of the nursing administration staff. At the time of inspection, there was no resident suspected or confirmed with COVID-19 while a small number of staff were isolating due to a COVID-19. Following an opening meeting with the person in charge, the inspector walked through the centre with the assistant director of nursing (ADON) and met with a number of residents in their bedrooms and in the dining rooms.

Birr Community Nursing Unit is a single story, purpose built facility that is registered to accommodate 76 residents in both single and multi-occupancy bedroom accommodation across three distinct units. On the day of inspection, there were 60 residents living in the centre.

Each unit had bright and spacious corridors that promoted the safe and free movement of residents with handrails fitted to provide additional support. Corridors were easily navigated as they were well signposted to orientate residents as to their precise location and were brightly lit through natural and artificial lighting. There was central access to enclosed secure gardens that had comfortable seating areas and a hen coup for residents to enjoy. Residents were observed to be freely walking through the corridors, chatting with one another, listening to morning mass and some were sitting near the nurses station chatting to staff as they passed by. While the centre was found to be clean in areas occupied by residents, further attention to cleaning was required in store rooms, treatment rooms and sluicing facilities. The inspector observed areas throughout the centre that required repainting due to general wear and tear and the person in charge confirmed that a programme of works was being developed to address these issues. Floor coverings were well maintained and easily cleaned.

Some beds had been removed from multi-occupancy bedrooms and this resulted in additional space for residents. Since the previous inspection, these vacant spaces had been reconfigured for use by residents. A number of residents confirmed in

conversations with the inspector that they liked having more living space and were happy that they had more space to store their belongings. It also provided more room for storage of clothing and personal possessions such as photographs and ornaments.

Over the two days of the inspection, most residents were seen to spend a significant amount of time in their bedrooms. Communal space was extremely limited in both Laurel and Camcor units and there was very little opportunity for residents to leave their rooms. Dayrooms were observed to be dual purpose as they also served as each unit's dining room. The inspector observed that dining room tables occupied the majority of the room space and this resulted in limited space and furnishings that would be expected in a dayroom for residents to relax in. The Sandymount unit dayroom was slightly larger due to the removal of a wall partition into a living room. This space was now an open plan dining room with a small seating area and television but it was not adequate to accommodate all residents living on the unit.

The inspector spoke with ten residents in their bedrooms and the resident's feedback mirrored the inspector observations. Feedback was that dayroom space in each unit was limited and small in size. As a result, many residents told the inspector that they felt more comfortable staying in their bedroom as the dining room, outside of meal times, was not an appealing area to spend their day or relax in. Residents told the inspector that the dining room and dayroom combination was less than ideal as it did not help 'break up the day' through a change of environment. Some of the more independent residents had the choice of leaving their unit to attend the larger dining room in the centre that served all three units.

The inspector had the opportunity to observe the residents dining experience. Meal times were observed to be a calm, relaxed and unhurried. Staff were supporting some residents in a discreet and respectful manner and there was polite conversation. The inspector observed that only a small number of residents attended the units dining rooms. For example, there were six residents in the Laurel unit dining room for lunch. When asked, some residents having lunch in their bedrooms said they would not go to the dining room as it was too small but they would be attending the dining room later in the day for activities. Residents to whom the inspector spoke with were complimentary of the quality of their meals and confirmed that they were provided with a choice at meal time. The menu was displayed on a white board in the dining room. Some residents had specific nutritional requirements and these needs were met. Teas, juices and snacks were readily available for residents.

Activities were provided daily by activities staff and the activity schedule was displayed on each unit. Activities observed during the inspection included baking and bingo. Staff were also observed assisting residents to walk outside and enjoy the mild weather. Two residents were observed enjoying a movie in one dayroom. Resident to whom the inspector spoke with were complimentary of the activities programme and detailed that past activity events that had taken place in the centre. This included a 'wellbeing week' that was filled with entertaining activities such as a fancy dress barbeque, live music, pet farm, talent show and baking competitions. A newsletter had been prepared reflecting the events of the week and circulated to

residents, relatives and staff. Some residents expressed dissatisfaction with the provision of consistent activities. When discussed in detail with residents, it was evident that staffing levels were impacting on the provision of activities. Residents had access to religious services in the centre on a weekly basis and also through live stream on television or radio. Ministers from other religious denominations visited residents in the centre regularly and as required.

The inspector acknowledged the challenging time residents, relatives and staff had been through as a result of the COVID-19 restrictions and outbreak in the centre. Residents told the inspector that they found the restrictions 'incredibly difficult' and that receiving the vaccination had provided them with some relief knowing they were protected. Residents complimented the efforts of the staff and management to keep them safe. Residents detailed how staff supported them to maintain contact with their relatives during restrictions. This included window visits, social media and regular telephone and video calls. Visiting had resumed in the centre and visitors were observed being guided through the centres infection, prevention and control procedures prior to entering each unit. The inspector had the opportunity to speak to a small number of visitors that expressed their delight at being able to visit residents in the centre again.

Residents and visitors were aware of the procedure to raise a complaint with a member of staff. Residents told the inspector that their feedback was regularly sought through conversations with the management team and through completing surveys to inform ongoing quality improvements in the centre.

The following section of the inspection report details the capacity and management arrangements in the centre and how this supports the quality and safety of the service provided to residents.

## Capacity and capability

The inspector found that Birr Community Nursing Unit had a responsive, consistent and established governance and management structure that was accountable and responsible for the quality and safety of the service provided. Actions to address non-compliances found during the previous inspection had mostly been addressed. However, improved oversight was required in the following areas to support the quality and safety of the service provided. This included:

- Staffing.
- Staff training and development.
- Oversight of risk identification.

This was an unannounced risk based inspection conducted over two days by an inspector of social services to:

- Follow up on an application to remove condition 4 and vary condition 1 on

the centres current registration.

- Follow up on the actions taken to address the non-compliances found in the previous inspection.
- To review the centres infection, prevention and control standards and the COVID-19 preparedness plan.

The centres registration was previously renewed in October 2020 following an inspection in June 2020. The June 2020 inspection found non-compliance in areas of the premises, residents rights, privacy and dignity, records and infection, prevention and control. These deficits related to the environment having a negative impact on the privacy, dignity and quality of life of residents living in the centre.

In response to these regulatory non-compliances, the Chief Inspector renewed the registration of this centre with an additional restrictive condition attached to the registration. This condition was aimed at improving the quality of life for residents ,particularly in the areas of the premises and improving the privacy and dignity and access to personal possessions for residents. The registered provider was required to comply with this condition by 31 December 2020 and the registered provider applied to remove this restrictive condition in September 2021 and to vary condition 1 of their registration to re-purpose and reconfigure the layout and design of rooms in the centre.

On this inspection, it was found that there were improvements in the facilities provided to residents that had a positive impact on their privacy and dignity through the provision of en-suite shower facilities and overhead tracking hoists in all bedrooms. Some multi-occupancy bedrooms had previously been reduced from four beds to three beds. The inspector observed that the layout of these rooms had been changed to provide residents with additional and usable space. However, protecting the privacy and dignity of residents in multi-occupancy bedrooms continued to present an issue. The findings in regard to application for the variation of Condition 1 is discussed further under Regulation 17: Premises in the quality and safety section of this report.

The management team consisted of a general manager, a manager of older person services and the person in charge. The person in charge had good clinical oversight of the service provided and information was communicated on a daily basis from the clinical team in terms of residents who were at risk of malnutrition, incidents, wound care, 'as required' medication administration and residents that required medical review. The person in charge was the COVID-19 lead in the centre and was supported by an infection prevention and control nurse lead who was responsible for auditing and monitoring compliance with the standards. However, staffing challenges had delayed the full implementation of this role in completing IPC specific audits such as hand hygiene. The person in charge was also supported was supported by an assistant director of nursing.

At the time of inspection, the registered provider had voluntarily capped admissions at 60 due to ongoing planned and unplanned leave of staff and challenges in the recruitment of staff. There were 22 vacant posts across multiple disciplines including nursing management, nursing, healthcare assistants and multi-task attendants.



Positions were currently being advertised and in the interim, the staffing levels were supplemented by the use of agency staff.

The team providing direct care to residents in each of the three unites consisted of a team of nurses and healthcare assistants and a clinical nurse manager who supervised the care provided to residents and reported to the assistant director of nursing and person in charge. Each unit was supported by a team of housekeeping, catering and activities staff. Night time staffing levels comprised of one nurse and one healthcare assistant on each unit and one night supervisor to supervise staff. While staffing levels were maintained in regard to the direct provision of care over the course of the inspection, rosters reviewed by the inspector evidenced significant challenges in ensuring that an appropriate number and skill mix of staff were on duty at all times to meet the assessed needs of the residents. Staff were redeployed from clinical supervision roles to provide direct nursing care to residents and activities staff were redeployed to the role of healthcare assistants. This had a negative impact on the systems to monitor the quality and safety of the service and the supervision of staff.

Record-keeping and file-management systems were in place and records reviewed were appropriately maintained, securely stored and made available to the inspector. The inspector reviewed a sample of staff personnel files that were found to contain the information as required by the regulation. Staff were supported and facilitated to attend training relevant to their role such as fire safety training, cardio-pulmonary resuscitation (CPR), infection prevention and control and the safeguarding of vulnerable adults. The training records evidenced gaps in the training to support residents with responsive behavior (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The person in charge had risk assessed this deficit and provided assurance that this training would be completed following the inspection. Further gaps were identified in manual handling and safeguarding training. Staff were confident in their knowledge of the procedure to take in the event of fire alarm activation and their role and responsibilities in protecting residents from abuse. Staff were clear on the procedure to follow should a residents or staff display symptoms consistent with COVID-19.

The policies and procedures, as required by the regulations, had been reviewed and updated since the person in charge was appointed in March 2021. The policies and procedures were made available to staff.

The person in charge was responsive to the receipt and resolution of complaints in the centre. The complaints procedure was displayed prominently in the centre and residents, visitors and staff were aware of this procedure. The centre maintained a complaints log. The inspector was assured that all complaints were documented and appropriately actioned to the satisfaction of the complaints. The documentation required improvement to ensure all actions taken were clearly recorded within the complaints log.

The centre was subject to an outbreak of COVID-19 in January 2021. A total of 10 residents and 10 staff had contracted the virus and sadly, three residents that

contracted COVID-19 had died. The inspector acknowledged that residents and staff living and working in the centre had been through a challenging time. It was evident that staff had made best efforts to protect residents and had acted swiftly to contain the outbreak. The inspector reviewed the management of the outbreak and this is discussed further under the quality and safety section of this inspection report.

There were systems in place to monitor the quality and safety of the service provided. This included an audit schedule that assessed the centres performance with infection, prevention and control standards, falls analysis, the quality of end of life care, medication management and care plan documentation. While all deficits identified had a corresponding action plan, some actions required review to ensure they were time-bound and a date for completion identified. There was evidence that feedback was sought from residents and was utilised to inform quality improvements in the centre. The annual review of quality and safety of the service for 2020 had been completed. Records and minutes of governance and management meetings evidenced that there was ongoing communication with staff regarding changes in the service and areas requiring improvement. Quality and governance meetings held via teleconference with the general manager discussed issues such as risk, fire safety, IPC, complaints and staffing. Some improvement was required in the systems of risk identification in the centre to ensure controls were in place to mitigate risks and maintain a safe environment for residents and staff.

### Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had made an application to remove condition 4 from their registration and to vary condition 1 of their registration.

The requirements of the regulations were submitted by the registered provider.

Judgment: Compliant

### Regulation 15: Staffing

Rosters provided to the inspector for review evidenced that there was significant challenges in maintaining an appropriate number and skill mix of staff on duty each day to meet the assessed needs of the residents. As a result of this, the centre had capped admissions at 60 residents. Staffing was supported by the use of agency staff and on occasions the staffing requirements could not be maintained when agency staff could not be provided. For example:

- Clinical nurse managers were required to suspend their supernumerary and clinical supervision time to fill deficits in the nursing care roster.
- Healthcare staff were rostered to cover a deficit in the nursing roster when nursing staff were unavailable.

- The night supervision was required to fill a vacant night nurse position on one unit. This impacted on the available staff to respond to a fire alarm activation.
- Activities staff were redeployed to healthcare assistant duties when there was a shortage in the healthcare assistant roster and this impacted on the provision of consistent meaningful activities for residents.
- Housekeeping staff were redeployed to catering duties to cover unplanned leave. This resulted in a reduced cleaning schedule of deep cleaning on the day of inspection.
- Staff reported being unable to provide supervision for residents, outside of each unit, in areas such as the larger dining room that served all three units and as a result this areas not accessible to residents who required supervision and assistance. This was due to ongoing staffing issues.

On occasions, the instability of the staffing rosters impacted on the continuity of residents care such as the provision of showers on days when there was a staff shortage. However, residents were provided with bed baths as an alternative and offered a shower later in the week when staffing levels were as planned.

Judgment: Not compliant

## Regulation 16: Training and staff development

Further analysis of staff training needs was required to ensure that staff were appropriately trained to carry out their duties effectively and safely. For example:

- A significant number of staff had expired manual handling training.
- There were some gaps in the training records for safeguarding of vulnerable adults.

The training matrix provided to the inspector required review to ensure it contained the records of all mandatory training described in the centres policy on staff training and development.

Further supervision of staff was required to ensure the cleaning procedure was implemented in areas of the centre identified as requiring further attention, such as the laundry, store rooms and sluicing facilities.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

A directory of residents was maintained and detailed all the information regarding each resident as required by the regulation.

Judgment: Compliant

### Regulation 21: Records

A sample of staff files were reviewed by the inspector and they were found to meet the requirements of the regulation. Safe and effective recruitment practices were in place to recruit staff. Staff files contained a valid An Garda Síochána (police) vetting disclosure on file and the person in charge gave assurance that all staff employed in the centre have a valid disclosure on file prior to commencing employment.

A sample of resident records reviewed by the inspector evidenced that daily nursing records were maintained and detailed the residents health, care needs and support provided to meet the residents needs.

Judgment: Compliant

### Regulation 23: Governance and management

The centre had clearly defined, accessible, governance arrangements and structures in place that set out lines of authority and accountability. Improvement was required in the oversight of available staffing resources.

Regular audits were carried out to assess, evaluate and improve the provision of services in a systematic way in order to ensure a safe and quality service was provided to residents. However, improvements were required to ensure that deficits in the service, identified through audits, were appropriately actioned within a defined time frame. For example, the provision of hand hygiene sinks and the remedial and replacement works required on fire doors.

The system of risk identification required improvement. The inspector observed a number of risks on the day of inspection that were not entered into the local risk register. For example:

- The storage of general, recycling and glass waste bins in the enclosed garden. Bins were not securely stored and presented a risk to residents in their current location.
- The risk of cleaning chemicals left on top of cleaning trolleys that were left unattended.
- The risk associated with a number of fire doors identified in a recent audit that required replacement or remedial works.
- A risk assessment was not completed in regard to visitors to multi-occupancy bedrooms.
- The risk associated with no call bell in the area used by residents who smoke.

The quality of care and experience of residents required further monitoring and action. For example:

- Residents surveys contained feedback regarding the provision of activities and the size of dayrooms but appropriate action had not been taken to resolve these issues as they persisted.

Judgment: Substantially compliant

### Regulation 3: Statement of purpose

The statement of purpose did not accurately describes the services provided. For example:

- The statement of purpose (SOP) was not updated to include the addition of showers to 12 bedrooms.
- The living room in the Sandymount unit was no longer present but had not been updated in the SOP.
- Bedroom five on the Laurel unit was identified as a three bedded room in the statement of purpose when it is in fact a four bedded room.
- The available staffing whole time equivalents (WTE) were not aligned with the WTE described in the statement of purpose.

Judgment: Substantially compliant

### Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre which was displayed at the reception. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. The inspector viewed a sample of complaints, all of which had been resolved.

Judgment: Compliant

### Regulation 4: Written policies and procedures

Inspectors reviewed the Schedule 5 policies that are required to be maintained in the centre. Policies had been updated in 2021 following the appointment of the person in charge and were made available to staff.

Judgment: Compliant

## Quality and safety

Overall, the inspector observed that residents in this centre received a good standard of care from a dedicated team of staff who knew their individual needs and preferences. However, the inspector observed that the instability in the staffing resources and the requirement for unit managers to cover nursing shifts was impacting on the oversight of specific aspects of the service that ensured a quality and safe service was provided to residents. This included:

- Infection, prevention and control.
- The premises.
- Residents rights.

Improvements had been made in regard to the premises since the previous inspection. Overall, the premises was bright, well maintained and clean in areas occupied by residents. Residents had unrestricted access to secure pleasant outdoor garden space. However, there was inadequate communal space available for residents. This was in part due to rooms being occupied by staff for breaks. Dayrooms also served as the dining rooms which impacted on available dayroom space for residents to relax and enjoy. As part of the application to vary condition 1 of the registered providers registration, the inspector was informed that internal minor building works had occurred in the nursing administration section of the building. Additionally, an activities room had been converted to a hair salon and a 'snack shop' was converted to a PPE store room. Further findings in regard to premises and the application to vary a condition of registration are discussed under regulation 17: Premises.

Discussions with staff and management and a review of the documentation showed that COVID-19 outbreak management plans had been developed and reviewed on a continuous basis. The management team reported that the COVID-19 preparedness and contingency plan had worked well in practice. Management were supported by Public Health, an Outbreak Control Team (OCT) and guidelines were issued and implemented to manage the outbreak that had been contained to one unit. A review of the management of the COVID-19 outbreak had been completed and included lessons learned to ensure preparedness for any further outbreaks.

Each unit was staffed with two housekeeping staff who demonstrated a clear understanding of the cleaning procedure and this was observed to be in practice. A domestic supervisor oversaw the implementation of the cleaning policy and procedure and monitored the quality of cleaning and hygiene in the centre. Colour coded cloths were in use to reduce the risk of cross infection and mop heads were changed after use in each bedroom. The inspector observed many good practices on the day of inspection that included:

- Twice daily symptom checking of residents and staff.
- Hand sanitiser dispensers placed at the point of care.
- Signage strategically placed to prompt staff, residents and visitors to perform frequent hand hygiene.
- Floor coverings were easily cleaned.
- There was a schedule for cleaning and decontaminating curtains and fabrics.
- Individual hoist slings for residents.

Notwithstanding the positive control measures in place, the inspector identified additional opportunities for improvement to support the staff efforts in maintaining a good standard of infection prevention and control and to further protect residents from the risk of infection. For example, access to clinical hand hygiene sinks in the centre were not sufficient. While this had been identified in a recent audit, a timeline for completion of this action was not evident. Further findings are discussed under Regulation 27: Infection Control.

The inspector reviewed the centres maintenance and testing records in respect of fire safety and all documents were available for review and up-to-date. Daily checks of means of escape were documented and escapes were observed to be unobstructed. Each resident had a personal evacuation plan in place. Staff had completed a fire evacuation drill simulating night time staffing levels and there was evidence of learning from this exercise and areas for further improvement. Staff demonstrated a clear understanding of the evacuation procedure. The inspector released a number of fire doors and observed that some doors did not fully close while other doors were damaged resulting in a gap between the seals.

The centre had a risk management policy and maintained a risk register that was updated as risks were identified. Controls were put in place to mitigate the risk. Hazard analysis formed part of the management teams role and this supported the health and safety needs of the residents. Serious and non-serious incidents were logged, investigated and appropriate action was taken.

The clinical care records were maintained to a good standard. Each resident had a comprehensive assessment completed prior to admission to the centre and risk assessment were completed at intervals not exceeding four months following this. Care plans were developed from assessment such as the risk of malnutrition, falls, dependency needs and risk of impaired skin integrity. Care plans clearly described the clinical and social care needs of each resident and provided guidance on meeting the needs of the residents. Care plans were developed and reviewed in consultation with the residents and ,where appropriate, their relatives.

Residents had unrestricted access to their general practitioner (GP). There was a system of referral in place to health and social care professionals such as dietitian services, speech and language, tissue viability expertise and psychiatry of later life.

Inspectors observed staff engaging with residents who exhibited responsive behavior and engagement was calm and non- restrictive. There had been a reduction in the use of bedrails in the centre and the person in charge informed the inspector that the centre promoted a restraint free environment. Where bedrails

were used, there was supporting risk assessments, consent obtained and multidisciplinary team involvement. Alternatives were trailed such as low beds and safety mats prior to using bedrails. However, improvement was required in the documentation on the use of 'as required' medications. This is discussed further under Regulation 7: managing behavior that is challenging.

Resident's bedrooms were decorated with items of significance to each individual resident. Residents clothing was laundered on-site and returned to residents promptly and residents reported being satisfied with this service. Residents in multi-occupancy bedrooms had decorated the additional space made available by the removal of a bed with ornaments, books and personal items.

Residents were supported to exercise choice in their activities of daily living and staff supported residents to carry out activities that they enjoyed doing. Residents were kept informed about changes in the centre such as visiting guidelines. Residents had access to daily local and national newspapers, radio and televisions were available in all bedrooms with additional televisions being installed in multi-occupancy bedrooms to facilities residents who may wish to watch a programme of their choice without impacting on the choice of others. Residents were observed to have their individual style and appearance respected and were supported by staff to maintain this. Resident surveys evidenced that overall, residents were satisfied with the service provided with the exception of the provision of activities and the size of the dayrooms. Residents had limited choice about where they would spend their day and this was particularly significant for residents in shared accommodation.

### Regulation 11: Visits

Visits were being facilitated in line with the current COVID-19 Health Protection Surveillance Centre (HPSC) guidance on visiting long term residential care facilities.

Residents were supported to maintain personal relationships with relatives and friends. Each resident had a visiting care plan in place that details their individual preferences in regard to receiving visitors.

Judgment: Compliant

### Regulation 12: Personal possessions

Residents in both single and multi-occupancy bedrooms had access to secure storage in which they could store their personal possessions and clothing. Residents were encouraged to personalise their private space which created a homely feeling in many of the bedrooms.

The inspector viewed the laundry facilities in the centre. Residents personal clothing



was laundered on site and there was a system in place to minimise the risk of items of clothing being misplaced through discreet identification labels on clothing. The laundry system minimised the risk of cross contamination and the clean and dirty areas were clearly defined.

Judgment: Compliant

## Regulation 17: Premises

The inspector reviewed changes to the layout and occupancy of two multi-occupancy bedrooms on the Cancor unit. Bedroom two on the Camcor unit had been reduced from four beds to three beds and bedroom six had been increased from three beds to four beds. This meant that:

- The number of beds in bedroom six now meant that there was insufficient distance between beds which meant residents rights to privacy and dignity was compromised. This bedroom, in its current configuration, will not comply with S.I. No 293/2016 due to come into effect on 01 January 2022.
- As found on the previous inspection, curtain screens in multi-occupancy bedrooms provided visual protection for residents but these screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy bedroom accommodation.
- The reduction of beds in bedroom two now provided residents with additional and usable communal space within their bedroom to store personal possessions and use at their leisure.

Furthermore, a second four bedded multi-occupancy bedroom on the Laurel unit, in its current configuration, required review to ensure that it complies with the requirements of S.I. No 293/2016 due to come into effect on 01 January 2022.

In addition to the multi-occupancy nature of the bedrooms, there was limited communal space for residents to spend time away from their bedrooms, meet visitors in a private space or have confidential discussions with the staff. This was further reduced because:

- The parlor room was used by staff for breaks.
- The family room on each unit was used by staff for breaks.
- The large dining room / dayroom that served all three units was not used to its full capacity due to supervision requirements impacted by the challenges with staffing.

As a result, residents were not provided with the minimum of 4 square metres, for each resident, of communal space as recommended in the National Standards for Residential Care Settings for Older People in Ireland (2016).

There were areas of the premises that required painting, redecoration and maintenance. Some equipment used by residents also required replacement. For

example:

- Housekeeping store rooms chipped paint and exposed plaster that required attention.
- Corridor walls had scuff marks and minor chips in the paint.
- Taps in the sluice rooms were dripping and had limescale build up on the faucet.
- Some equipment such as commodes required replacement due to rust on the wheel castors.
- Grabrails on some toilets were heavily rusted at their base connection to the floor. This compromised effective cleaning

There was inappropriate storage of items throughout store rooms.

- A treatment room had multiple boxes and clinical equipment stored on the floor and the hand wash sink was inaccessible as a result.
- A table was stored in an assisted bathroom with mobility aids.
- Hoists were observed to be stored in bedrooms occupied by residents.

Judgment: Not compliant

### Regulation 26: Risk management

The risk management policy contained the risks and actions taken to mitigate the risks identified and required by regulation 26(1)(c). The policy had been reviewed and updated following a serious incident in the centre and controls put in place to reduce the risk of recurrence. A critical incident review had been completed by the person in charge and there was evidence of learning from serious or adverse events involving residents.

The person in charge had completed a COVID-19 outbreak review that evidenced learning from the outbreak and areas of the response plan that required improvement.

The systems of risk identification required improvement and this is actioned under Regulation 23: Governance and Management.

Judgment: Compliant

### Regulation 27: Infection control

Infection prevention and control practices required further oversight to ensure best

outcomes for residents. A number of issues that had the potential to impact on infection, prevention and control measures were identified during the course of the inspection. For example:

- There was inappropriate storage of items in sluice rooms such as vases, candle stick holders and toiletries stored in cupboards. This increased the risk of cross contamination and impacted on effective cleaning of the area.
- Used linen bags were found on the ground of sluice rooms beside a bag of clinical waste awaiting disposal.
- There was a limited number of hand hygiene sinks on each unit. Multi-occupancy bedrooms contained hand hygiene sinks but single bedrooms did not and in some cases the nearest hand hygiene sink was in a sluice room or assisted bathroom.
- Cleaning trolleys on each of the units were visibly unclean. Effective cleaning and decontamination is compromised if cleaning equipment is contaminated.
- Store rooms and the laundry room were not clean.
- Further supervision of staff was required to ensure adherence to standard precautions. For example, the wearing of face masks.
- As found on the previous inspection, the number of beds in the multi-occupancy bedrooms did not ensure that all residents occupying the room would be protected from the risk of cross infection. For example, the distance from one bed space to the adjacent bed space did not support residents to move freely or sit out in a chair within their space while maintaining physical distancing.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The following fire risks were observed on the days on inspection:

- The inspector released a number of fire doors and some were observed to have damaged seals which created a gap between the doors when closed while other doors were damaged at their base.
- A fire door assessment had been completed by a competent person in August 2021 and a significant number of doors required either replacement or remedial repairs. A time line for completion of works was not evident and assurance had been requested on the day of inspection in this regard.
- Some fire doors were observed to be wedged open with chairs. For example, the oratory doors.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of residents care plans and saw that each resident was comprehensively assessed on admission to the centre ,and regularly thereafter ,using a range of validated assessment tools. Residents were assessed for the risk of malnutrition, falls, impaired skin integrity, dependency and oral hygiene care needs. Social activity assessments were completed and these informed the development of person-centre social care plans.

Assessments informed the development of care plans that detailed the clinical and social care needs of the residents and provided appropriate guidance to staff. Consultation with the residents was evident and this contributed to ensuring person-centred care was provided to residents.

There was evidence that recommendations made by health and social care professionals was updated into the residents individual care plan and this was communicated to the resident and, where appropriate, their relatives.

Judgment: Compliant

### Regulation 6: Health care

The health and wellbeing of each resident was promoted and residents were given appropriate support to meet any identified healthcare needs.

Records reviewed evidenced that residents had timely access to the expertise of health and social care professionals. Occupational therapy, physiotherapy, speech and language therapy and tissue viability expertise were available on referral to review residents. Residents identified at risk of malnutrition were appropriately referred to dietetic services for further review and residents weights were closely monitored for progress of the implemented treatment plan.

Where changes in treatment was indicated, this was appropriately updated into the residents care plan and prescription records. Residents had access to physiotherapy services to support resident at risk of falls.

Judgment: Compliant

### Regulation 7: Managing behaviour that is challenging

The inspector reviewed the records for some residents prescribed the use of 'as required' psychotropic medications.

Records did not evidence the non-pharmacological interventions, or least restrictive

actions, trialled prior to administering medication in response to incidents of responsive behaviour as described in the centres own policy and procedure on the use of restraint.

Records did not consistently detail if the resident obtain relief from their symptoms after the medication was administered.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

Improvement was required to ensure that each resident was offered a choice of appropriate recreational and stimulating activities to meet their needs and preferences. Many residents were observed in their bedrooms during the inspection and were not provided with meaningful activities. Residents and staff reported that staffing levels impacted on the provision of consistent activities and residents reported spending long periods in their bedrooms without being engaged in meaningful activities when staff were redeployed to other roles.

As already stated in this report, a review is required of the bedrooms, communal and private space available to residents to ensure that the rights of each resident are protected and that residents have a right to self determination in relation to daily activities, recreation and their lived experiences.

- While privacy screens provided visual protection, they did not adequately protect the privacy of residents in relation to the conduct of personal activities and communication. These screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy accommodation.
- Dining rooms were too small to accommodate the number of residents living on the units and meant that some residents had no choice but to have meals in their bedroom.
- Dayroom space was not accessible to all residents as the space was also occupied by dining room tables and chairs.
- Residents in multi-occupancy bedrooms were observed receiving visitors at their bedside when other residents occupied the room. This did not support the residents rights to receive visitors in private or support other occupants privacy.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Birr Community Nursing Unit OSV-0000522

Inspection ID: MON-0034257

Date of inspection: 14/10/2021

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non-compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The number of residents accommodated continues to remain capped at 60 residents to ensure the care needs of residents can be met in a person centered manner.</p> <p>A recruitment campaign is currently being progressed with interviews scheduled for week commencing the 22 Nov 2021.</p> <p>The staff numbers and skill mix are reviewed on a daily basis to ensure staff levels are adequate to meet the assessed needs of all residents. HSE staff undertake additional work shifts to mitigate any shortfall. A risk assessment has been completed with controls identified in relation to the redeployment of staff to cover unplanned absences. Any deficits are reported to the PIC for review and work tasks are reprioritised to meet resident's individual and collective needs.</p> <p>Regular agency staff are booked to work a regular rostered shift pattern to ensure continuity and familiarity of care for residents.</p> <p>All agency staff are facilitated to attend professional development training available onsite. All agency staff complete mandatory training, have access to HSE-Land online programs and are facilitated to attend additional professional training and education that is provided onsite.</p> <p>An additional recruitment campaign is planned to recruit Healthcare Assistants and Multi Task Attendants to increase the staff numbers.</p>	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	



staff development:

The staff training matrix has been reviewed and updated to record and accurately reflect the mandatory and professional development training completed by each staff member. The matrix has been revised to record all training and refresher programs delivered to staff in line with the centre's policies and procedures to ensure oversight of training and assist planning refresher training in the required timeframe.

Training in Safeguarding Vulnerable Adults has been completed by all staff.

Nine staff requiring refresher training in Safe Moving and Handling are being booked for training as a matter of urgency. A risk assessment has been completed in relation to this training deficit which has been escalated to senior management. This action is expected to be completed by 31/12/21 and the training matrix will be updated accordingly. Two senior staff are undertaking a Train the Trainer Course to become Moving and Handling Instructors. It is planned that there will be two staff certified in train the trainer in Moving and Handling by 31/01/22. This resource will ensure all future refresher training will be available onsite and scheduled according to staff training needs.

The frequency of auditing the cleaning procedures will be reviewed to ensure all cleaning is implemented in accordance with the cleaning policy and procedures. The domestic supervisor has implemented a system of documented cleaning checks on a routine basis

Regulation 23: Governance and management

Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The risk register has been reviewed and updated. A weekly review of the risk register and audits is in place to ensure corrective action is implemented for any learning identified.

New cleaning trolleys have been provided which contain a lockable area for the storage of cleaning chemicals.

A risk assessment has been completed in relation to the external secure storage of clinical, domestic and recycling waste to ensure that it does not present a risk to any resident/member of the public utilizing the garden areas in BCNU. Additional controls include the ordering of secure storage units. It is planned that these will be in place by 15/12/21. Additional staffing has been implemented to increase supervision of residents.

A local risk assessment has been reviewed in relation to visible damage to fire doors. The risks identified have been escalated to senior management and approval has been received for immediate commencement of remedial works to fire doors. The defective fire doors will be replaced or have necessary upgrade work completed to ensure they are operating in accordance with infrastructural standards for fire safety.

It is planned that these works will commence before 1/12/21. A fire risk assessment of the building by an external consultant is planned for 30/11/21 to assess all fire precautions.

A call bell will be fitted in the external smoking area. A review of all communal areas will be completed to assess the need for any additional call bell points to allow the residents summon assistance if they require support. The expected date for completion of this work is 15/12/21.

A review of the number and provision of accessible wash hand basins is being undertaken in conjunction with recommendations from the IPC nurse lead for the service. The expected date for completion is 31/01/22.

The feedback from resident satisfaction surveys completed in relation to the provision of activities and communal space is being considered. The room known as the Parlour has been identified as a living room for use by the residents on the Camcor suite and plans are in place to refurbish it in accordance with residents' preferences.

Residents on the Sandymount and the Laurel Suites will be encouraged and facilitated to have their main meals in the main dining room. Risk assessments are being completed to identify additional resources that will be required to implement this change. This will include a review in relation to staffing, to ensure appropriate supervision of residents with high levels of dependencies attending the main dining room. The dayroom & dining room on the Sandymount Suite and the dayroom on the Laurel suite will also be refurbished in consultation with the residents. The dining tables and chairs will be removed and will be replaced by seating more suitable for a living room. These changes will be discussed at the Resident Action Group meetings.

The front reception area has been decorated to a high standard to provide a homely experience for residents and as an additional space to accommodate visiting from family and friends.

Regulation 3: Statement of purpose	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Statement of Purpose has been updated to include the addition of showers to 12 bedrooms.

The living room in the Sandymount suite has been updated in the Statement of Purpose. Bedroom 5 on the Laurel suite is identified on Statement of Purpose as a four bedded room.

The available staffing whole time equivalents are aligned with the WTE described in the Statement of Purpose.

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Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:  
 The space requirements of the two bedrooms presently registered to accommodate four residents have been reviewed. In order to meet the requirements of S.I. No 293/2016, it has been agreed with Senior Management, to include the Registered Provider and the Head of Social Care, that these two bedrooms will be reconfigured to three bedded rooms. The bed configuration will be reorganized in both bedrooms to ensure the privacy and dignity of residents accommodated. The completion date is 15/12/21. All bedrooms have full en-suite facilities comprising of a toilet and wash hand basin and an easily accessible shower. An overhead tracking hoist system has been fitted in all multi-occupancy bedrooms to ensure the moving and handling needs of residents can be met in a dignified manner within the screened bed space to protect their privacy and minimize any intrusion on other residents' personal space.

A risk assessment with controls in relation to residents meeting with their visitors in multi occupancy bedrooms is in place to ensure the best interest of the individual needs of each resident. The risk assessment and controls identified accounts for the privacy of residents and precautions in relation to public health guidance for visiting in residential care facilitates.

Additional bedside curtains have been purchased and delivered for each suite. Date for Completion 15/12/21.

The Parlor room is being reverted for resident use only, to provide additional recreation space for use by the residents.

The family room in each suite is for resident use only and is a private space available for residents to meet with their families and visitors in private.

Housekeeping rooms will be repainted and exposed plaster will be repaired. Corridor marks will be rectified and a cleaning schedule implemented with detailed cleaning procedures for this area. The taps in the sluice rooms will be repaired to rectify drips and cleaned to remove limescale. Completion Date 15/12/21.

Rusted commodes have been removed. New commodes are ordered.

Grab-rails on toilets will be repainted to ensure they are readily cleanable.

Multiple boxes have been removed from treatment room and clinical equipment stored appropriately.

The table has been removed from assisted bathroom.

One resident requested that her own hoist can be stored in her bed room space.

A capital plan has been submitted to apply for funding for 75 single rooms for Birr Community Nursing Unit to address the deficits in relation to limited spaces in dayrooms on each suite. In the meantime the large dining room at the front of the building is being reviewed in terms of accessibility and usage as a separate area for use by the residents

to enhance their living environment and provide additional space for recreation and leisure activities.

Regulation 27: Infection control

Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

All inappropriate items have been removed from sluice areas.

Enclosure in internal garden has been requested for storage of domestic waste and clinical waste bins.

A review of the number and location of hand washing facilities will be completed in consultation with the Infection Control Specialist to ensure an adequate number of hand washing facilities are available.

A cleaning schedule has been developed for cleaning trolleys with a specified procedure and frequency. Schedule in place to clean overhead piping and piping behind washing machines on a quarterly basis or as required based on visual inspection.

Store room cleaning schedule has been reviewed.

The Infection Prevention Control Lead will provide staff education sessions in relation to standard precautions and vigilance with mask wearing. The nurse management team will observe practice and supervise staff adherence to standard precautions and mask wearing. Planned spot checks have been implemented and the importance of mask wearing is discussed at safety pauses in each unit.

The space requirements of the two bedrooms presently registered to accommodate four residents have been reviewed and in order to meet the requirements of S.I. No 293/2016. These two bedrooms will only accommodate three residents each. The bed configuration will be reorganized in both bedrooms to ensure the privacy and dignity of residents accommodated.

Regulation 28: Fire precautions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:  
A local risk assessment has been reviewed in relation to visible damage to fire doors. The risk has been escalated to senior management and approval has been received for immediate commencement of remedial works to fire doors. The defective fire doors will be replaced or have necessary upgrade work completed to ensure they are operating in

accordance with infrastructural standards for fire safety. A quote has been obtained for fire door repairs and sent to Estates for processing. It is expected that these works will commence before 1/12/21.

A fire risk assessment of the building by an external consultant is planned for 30/11/21 to assess all fire precautions.

A self-closing device has been fitted to the Oratory door.

The daily fire checks have been amended to include inspection of doors to ensure they are not held open or obstructed from self-closing on the sounding of the fire alarm.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:</p> <p>The Psychotropic template has been amended to ensure that non-pharmaceutical interventions are documented and ABC charts are updated following administering of PRN medication.</p> <p>Any side effects of PRN medication is documented in the nursing notes. An adjustment has been made to the psychotropic register to ensure this information is documented.</p> <p>Each resident's medication is reviewed and audited by the pharmacist and any recommendations identified are communicated to the GP on reviewing the medication Kardex.</p>	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>The Parlor room has reverted to a day room for resident's use and provides a space for activities. The large dining room at the front of the building is being reviewed in terms of accessibility and usage as a separate area for use by the residents to enhance their living environment and provide additional space for recreation and leisure activities.</p> <p>Work is in progress to reintroduce external facilitators to support and enhance the current activity program in place. Options being explored include music sessions, physical and sensory programs. The reintroduction of activity programs will be supported by a risk</p>	

assessment with appropriate control measures put in place.

Family rooms will be made available for residents to spend quality time with their family and friends and ensure residents can meet their families and visitors privately. Additional seating supplied in front reception to accommodate residents and their visitors.

The space requirements of the two bedrooms presently registered to accommodate four residents have been reviewed and in order to meet the requirements of S.I. No 293/2016. These two bedrooms will only accommodate three residents each. The bed configuration will be reorganized in both bedrooms to ensure the privacy and dignity of residents accommodated.

A capital plan has been submitted to apply for funding for renovating Birr Community Nursing Unit to a 75 single room to address the deficits in relation to limited spaces in dayrooms on each suite. In the meantime, the large dining room at the front of the building is being reviewed in terms of accessibility and usage as a separate area for use by the residents to enhance their living environment and provide additional space for recreation and leisure activities.

## Section 2:

### Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	30/01/2022

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/01/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/10/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	15/12/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Substantially Compliant	Yellow	15/12/2021



	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	15/12/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/12/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/10/2021
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and	Substantially Compliant	Yellow	30/10/2021

	respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/01/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/01/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/11/2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/11/2021